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February 21, 2023

Good afternoon Senator Cabrera, Representative Wood and members of the Insurance and Real Estate Committee. I would like to offer comments on SB 983, AN ACT LIMITING ANTICOMPETITIVE HEALTH CARE PRACTICES, HB 6620, AN ACT PROMOTING COMPETITION IN CONTRACTS BETWEEN HEALTH CARRIERS AND HEALTH CARE PROVIDERS and HB 6710, AN ACT CONCERNING ASSOCIATION HEALTH PLANS. I have, for a number of years, worked to protect patients and to preserve the viability of independent providers and I am pleased that the Insurance and Real Estate Committee is tackling some of these issues this year. I believe that when addressing issues such as healthcare consolidation and pricing it is important to keep the patient as the North Star. When limiting these anti-competitive practices we must not sacrifice care quality and where these policies create savings, these must be shared with the patients and not just become a boon for the payers. The purpose of the system is, after all, to provide quality healthcare to patients.

SB 983 and HB 6620 strive to limit certain anti-competitive practices in healthcare contracting which is a goal I wholeheartedly support and have in past years proposed legislation to address (including SB 807[1] in 2015 and PA 15-146). . These bills would prohibit All-or-nothing clauses, anti-steering clauses, anti-tiering clauses and gag clauses. I do believe that these bills are works in progress and I look forward to working with you on these issues.

Both bills would prohibit "all of nothing" clauses which some large health systems use to force inclusion of all of that system's hospitals or none of them. An employer in New London might want to include L & M Hospital and Yale New Haven Hospital but not feel that it was necessary to include Greenwich Hospital as that is not geographically convenient. It would not adversely affect the employees but under all or nothing requirements this would not be possible.

In addition, the bills would both prevent the use of gag clauses; this is consistent with the provisions of federal law in the Consolidated Appropriations Act of 2021[2]. Allowing access to price and quality information is crucial to selecting high quality low

[1] https://cga.ct.gov/2015/FC/2015SB-00807-R000437-FC.htm
[2] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FAQs%20About%20ACA%20%26%20CAA%20Implementation%20Part%2049_MM%20508_08-20-21.pdf

cost care. Without access to this information patients, employers, and insurers have no basis for rational decision making.

Similarly, prohibiting anti-steering clauses can create sensible cost containment without damaging quality of care. Allowing and encouraging patients to choose high quality low cost providers can lower patient out of pocket costs without lessening quality of care. For example, encouraging patients to use independent (rather than hospital owned) radiology centers and infusion centers can provide equivalent care at a far lower cost. However, the legislation must ensure that patient care does not decrease and that patients share in the cost savings.

I have some concerns with the provisions that address out of network reimbursement. First, it is not always the provider's choice to be out of network. There are situations in which small providers would prefer to be in network but the insurer offers a reimbursement rate so low that would not allow the provider to keep its doors open. Sometimes the insurers use their negotiating power to pay the independent provider at such a low rate that the provider ultimately becomes part of a hospital system which increases the cost without improving the quality of patient care. Setting reimbursement at 100% of the Medicare rate is simply too low. It would create an incentive for insurers to keep providers out of network and would not decrease consolidation.

Similarly, banning anti-tiering clauses could lower out of pocket costs for patients, but this must include protections for patients including robust network adequacy requirements and a prohibition on removing access to providers during a plan year. If a patient selects a plan because it includes a specific provider, access to that provider should not change during the policy year. Again, I would refer to SB 807 from 2015 which supports the use of tiered networks but includes significant patient protections.

I am a bit puzzled as to why SB 983 creates a Connecticut Unfair Trade Practice Act violation but does not allow for a private right of action. I believe that generally CUPTA intentionally provides a private right of action.

SB 6710 authorizes self-funded and fully insured multiple employer welfare arrangements (MEWAs) in Connecticut. These are often referred to as Association Health Plans AHPs). Although this bill appears to require the plans it authorizes to follow some of the patient protections in the Affordable Care Act such as the essential health benefits, I am concerned that these plans would create adverse selection for the non AHP plans in the state. The American Academy of Actuaries explains some concerns regarding these plans.[3] .

[3] https://www.actuary.org/content/association-health-plans-0

Thank you for hearing these important bills and I am looking forward to working with you on these issues.